

PERSONAL & FAMILY HISTORY (please place an "X" in the WHITE boxes that apply)

PATIENT PAST MEDICAL HX & FAMILY HX

	You	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Brothers or sisters	Children	OTHER family members
Anemia										
Ashkenazi Jewish descent (Eastern European or Russian)										
Arthritis										
Asthma										
Birth defects (i.e. cleft palate, spina bifida.....)										
Clotting disorder, or deep vein thrombosis										
Blood disorders (ex. ITP, sickle cell...)										
Breast disorders										
Cancer, Breast										
Cancer, Colon										
Cancer, Ovarian										
Cancer, Uterine										
Colon polyps										
Diabetes										
Endometriosis										
Epilepsy										
Gallbladder disease										
Genetic disorders (i.e. mental retardation, cystic fibrosis...)										
Glaucoma										
Heart disease or MVP										
High cholesterol										
High blood pressure										
Kidney Disease/stones										
Mental Illness, type?										
Menstrual irregularities										
Osteoporosis										
Pelvic Inflammatory dis.										
Stroke										
Thyroid disease										
Uterine anomalies										
...Still Living?	X									
...Deceased at Age?	----									

OTHER DISEASES/ILLNESSES:

SOCIAL HISTORY

Marital Status (please check one):

Single/Not Dating Married
 Single/ Dating Divorced
 In a committed relationship Widowed
 Engaged

PARTNER'S NAME: _____ **Age:** _____

Safety: Do you feel safe in your current relationship: Yes No
 If not please explain _____

Have you ever been physically abused in a relationship: Yes No
 If so, please explain _____

Have you ever had an unwanted sexual encounter: Yes No
 If so, please let us know when this occurred: _____

Substance Use: Do you drink alcohol: Yes No
 How many drinks per day or week: _____
 Do you currently use any illicit drugs: Yes No
 Type _____
 How often _____
 Do you smoke cigarettes: Yes No
 How many per day _____
 How long have you been a smoker: _____

Occupation: _____

Do you Exercise: Yes No
 Type _____
 How often _____

Infection Risk:
 Are you currently sexually active? Yes No
 Sexual preference (circle one): Heterosexual Lesbian Bisexual Other
 How many sexual partners in the last 1 year? _____
 In your lifetime: 1-5__ 5-10__ 10-20__ 20+__

Have you ever had a sexually transmitted disease (STD)? Yes No
 Hepatitis (Type?) _____
 Syphilis (when? treated?) _____
 Chlamydia (when? treated?) _____
 Gonorrhea (when? treated?) _____
 Genital Herpes (taking meds?) _____
 HPV (human papilloma virus) _____
 Genital warts? _____
 OTHER _____

Have you ever had MRSA (Methicillin-resistant Staphylococcus aureus)?
 Yes No

PRINT NAME HERE: _____

REVIEW OF SYMPTOMS

Constitutional:

Frequent Fatigue
Excess weight gain
Excess weight loss

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A

Eyes, Ears, Nose, Mouth:

Frequent or severe headaches
Frequent lightheadedness

Circle One:

Current Past N/A
Current Past N/A

Breasts:

Lumps
Pain
Swelling
Nipple discharge

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Cardiovascular:

Chest pain
Fainting
Swollen/Painful varicose veins
Calf pain

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Respiratory:

Frequent shortness of breath
Frequent Hoarseness

Circle One:

Current Past N/A
Current Past N/A

Gastrointestinal:

Nausea/ Vomiting
Frequent Diarrhea
Frequent Constipation
Frequent Heartburn/ reflux
Abdominal Pain
Blood in stool
Hemorrhoids

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Genitourinary:

Urgency
Frequency
Pain with urination
Blood in urine
Frequent Urine leakage
Pain with intercourse
Genital sores

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Genitourinary (continued)

Irregular periods
Painful periods
Heavy periods
No periods
Possible pregnancy?
Abnormal vaginal discharge
Significant PMS

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Integument (skin):

New skin lesions
Changes to moles/skin lesions

Circle One:

Current Past N/A
Current Past N/A

Musculoskeletal:

Joint pain
Joint swelling
Recent back pain

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A

Endocrine:

Excess bodily hair growth
Excess hair loss
Cold intolerance
Heat intolerance
Acne
Thyroid abnormalities/ treatment?

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Psychiatric:

Frequent Anxiety
Frequent Depression
Suicidal thoughts
Psychiatric treatment

Circle One:

Current Past N/A
Current Past N/A
Current Past N/A
Current Past N/A

Hematologic/Lymphatic:

Easy bleeding
Easy bruising

Circle One:

Current Past N/A
Current Past N/A

List any other symptoms bothering you today: _____

YOUR HEIGHT: _____ YOUR WEIGHT: _____

PRINT NAME HERE: _____

PATIENT SIGNATURE: _____ DATE COMPLETED: _____

RENAISSANCE WOMEN'S GROUP, PA

Genetic Screening Questionnaire

NAME: _____

Will you be 35 years old or older at your due date? Y N

Are you or your baby's father of...

- Jewish background? Y N
- Black/African background? Y N
- Mediterranean background? Y N
- Asian background? Y N
- French-Canadian background? Y N

Have you...

- taken any medications (prescribed or OTC) during this pregnancy? Y N
- had any alcohol (beer, wine or hard liquor) during this pregnancy? Y N
- used any illegal/street drugs (cocaine, marijuana) during this pregnancy? Y N
- taken Accutane, blood thinners, or lithium since your last period? Y N
- had radiation therapy or chemotherapy since your last menstrual period? Y N
- take mega dose vitamins, especially vitamin A since your last period? Y N

Do you or your baby's father have epilepsy?

- and take medication? If yes type _____ Y N

Do you have diabetes or have you had diabetes with pregnancy and are/were you....

- on insulin Y N
- on oral hypoglycemic medications Y N
- controlled by diet Y N

Are you and the father of your baby first cousins or closer?

Y N

Have you had...

- three or more miscarriages? Y N
- had a stillborn infant? Y N
- a child that died within the first year of life? Y N

Have you, the father of your baby, or anyone in either family ever had a child

- | | <u>self</u> | <u>father</u> | <u>family</u> |
|---|-------------|---------------|---------------|
| • with Down Syndrome or other chromosomal abnormality? | Y N | Y N | Y N |
| • with mental retardation? | Y N | Y N | Y N |
| • with an open spine (spina bifida), skull defect, or anencephaly? | Y N | Y N | Y N |
| • with a heart defect? | Y N | Y N | Y N |
| • with a muscle or neuromuscular disease (muscular dystrophy)? | Y N | Y N | Y N |
| • with Cystic Fibrosis? | Y N | Y N | Y N |
| • with Hemophilia, sickle cell, thalassemia, or other blood disorder? | Y N | Y N | Y N |
| • with any birth defect or genetic disease not listed above? | Y N | Y N | Y N |

Patient signature _____ *Date* _____

CENTRAL TEXAS OB/GYN ASSOCIATES
PATIENT AUTHORIZATION FORM

Please read, initial, and sign below

(Initial)_____ FINANCIAL RESPONSIBILITY: I understand that I am ultimately responsible for payment on my account. Payment is expected at the time of service. I understand that I am responsible for any referral or authorization that my insurance may require and for any charges not covered by my insurance plan, including co-payments, co-insurance and deductibles. Claims will be filed for PPO and HMO participants, Medicare and Medicaid. Payment of benefits will be made directly to Central Texas OB/GYN Associates. I understand and accept that by paying with a check, I expressly authorize CTOA (through Chexpedia), to electronically debit my checking account for the amount of the check plus a processing fee of \$30, if my check is dishonored or returned for any reason. I also understand that if I do not pay all of the charges due from me and my past due account is sent to an outside collection agency, an additional fee equal to the collection agency's commission will be added to my outstanding balance.

(Initial)_____ INSURANCE COVERAGE: I understand that I am responsible for providing my physician with any and all insurance coverages at each and every visit. I will be responsible for any balances due as a result of not disclosing this information. (_____ Staff Initials)

(Initial)_____ LABORATORY FEES: I understand that my physician uses Clinical Pathology Laboratory (CPL). CTOA cannot guarantee my insurance will cover any lab/pathology performed at or ordered by my physician. If my insurance requires use of a different lab, I understand it is my responsibility to inform my physician for proper handling.

(Initial) I DO_____ I DO NOT_____ CONSENT to necessary examinations and/or treatments performed and prescribed by my physician, nurse practitioner or physician's assistant as is necessary in his/her judgment, with patient approval. **Separate consent forms will be signed for procedures performed in the physician's office.**

(Initial)_____ RELEASE OF INFORMATION: I do hereby authorize my physician to release information to the hospital facility in the event of a scheduled surgery or procedure, emergency care or pregnancy. I authorize the release of any medical records or other information necessary to process my insurance claim.

(Initial)_____ HIPAA: I acknowledge that I have received or have access to a copy of CTOA's Notice of Privacy Practices.

(Initial)_____ FEE FOR FORMS COMPLETION: I understand that I will be responsible for paying \$15 for forms completion by my physicians or staff. (Example: Disability forms, FMLA forms, etc.)

(Initial)_____ FEE FOR 'NO SHOW'. I understand that a \$25 'no show' fee will be assessed for appointments that I do not keep.

Spouse's Name: _____ Spouse's Work Phone: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Emergency Contact: _____ Emergency Phone: _____
(other than spouse)

Your signature: _____ **Today's date:** _____